DOCUMENT RESUME

ED 278 200 EC 191 767

AUTHOR Ranzoni, Patricia Smith
TITLE The Child Development Specialist in a Mental Health Center. Position Paper.
PUB DATE 86
NOTE 16p.
PUB TYPE Viewpoints (120) -- Reports - Descriptive (141)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Child Advocacy; Child Development; *Child Development Specialists; *Counselor Role; *Emotional Disturbances; *Mental Health Programs; Philosophy; *Program Development; Young Children

ABSTRACT

A child development team in a children's services unit of a mental health center should: (1) formulate a broad philosophy of treatment for young child clients; (2) evaluate treatment approaches to determine the extent to which they facilitate or conflict with that philosophy; (3) assess inservice training needs to ensure competency-based service delivery; (4) use all resources available to strengthen a compatible team approach; and (5) evaluate on an ongoing basis to ensure that the philosophy of treatment remains dynamic and reflects professional and programmatic growth. These standards should generate a service which considers treatment from the child's perspective and the child's rights to appropriate treatment, services, assessment, advocacy, and guidance. Although the ultimate responsibility for program philosophy rests with supervisors and program managers, each service provider and staff person is responsible for professional behavior, team accountability, and quality assurance standards and should remain alert to services provided to child clients, working toward conditions which model the highest quality in adult-child interactions. (CB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

ED278200

Patricia Smith Ranzoni
Star Route Box 173
Bucksport, Maine 04415

POSITION PAPER: THE CHILD DEVELOPMENT SPECIALIST IN A MENTAL HEALTH CENTER

Perspectives of a child development team supervisor in a community mental health center are discussed. Procedures benefiting bureacracies more than child clients are challenged.

I will know about, abide by, and advocate for laws and regulations that enhance the quality of life for young children.

I will support the rights of children to live and learn in environments that are responsive to their developmental needs.

I will improve my competencies in providing for children's needs.

I will appreciate each child's uniqueness, thus enhancing the child's self-respect.

-- Commitment to Children
National Association for the Education of Young Children

BEST COPY AVAILABLE

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Patricia S. Ranzoni
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

EC191767

Patricia Smith Ranzoni
Star Route Box 173
Bucksport, Maine 04416
207-469-2225

ABSTRACT

Experience-based concerns of a child development specialist working in a mental health center are discussed with a focus on considerations specific to providing services to young children. Advocacy is emphasized through a proposed process for determining a general philosophy of treatment, based on a statement of the rights of child clients. Proposed for discussion are specific recommendations related to assessment and treatment methodologies, quality assurance standards, interfacing with professionals from other disciplines, supervisor: supervisee relationships and responsibilities, teaming, facility management and record keeping. Policies and procedures designed to benefit bureaucracies rather than child clients are challenged, alternatives proposed.

RATIONALE

Because young children are especially vulnerable and without a voice or means of their own, protection and advocacy should characterize the systems through which professionals provide helping services. Those who do this work through mental health centers owe it to themselves, to individual and agency consumers, to funding sources, to the catchment area community, and above all, to child clients who need their support, to have a definable position and concomitant methodology for which they are accountable.

To operate under the assumption that a potpourri, anything goes approach, or to accomodate markedly opposing theories of treatment because of staff recruiting problems, reimbursability issues, or in the name of a multi-disciplinary team, leads to in-house conflict, confusion, and dissatisfaction from consumers and consulting agencies. Most unfortunate, however, in this denial of the special needs of young children and their families, is the message received by children who are the recipients of experimentation and inconsistency, and who may be abused or neglected by those very people who are mandated, indeed paid, to help.

Given the accumulated bodies of knowledge from human development and learning theory, certain treatment modes should be evaluated and selected or rejected according to the goals of treatment. Too often, young children are subjected to professionals and methodologies for reasons other than age or problem appropriateness.

To offer mental health services without a broad philosophy of treatment is like running a school without a philosophy of education or a

hospital without a philosophy of health care. Lack of this assurance for young children is a risk factor that should not be minimized.

There are treatment modes that are appropriate for young children and some that are not. It is the responsibility of the child development specialist in a community based mental health program to advocate for attention to age and problem appropriate service provision.

Determining a philosophy of treatment is an essential first step as a foundation for writing goals and objectives for program direction. Unless we as professionals can define for ourselves and others what we believe about how young children grow in the area of emotional development in an inseparable relationship to the physical, social and cognitive domains, and how the methods we use reflect that knowledge, we have no business selling our services.

Accordingly, I submit, a child development team in a children's services unit of a mental health center should:

1. formulate a broad philosophy of treatment for young child clients;
2. evaluate treatment approaches to determine the extent to which they facilitate or conflict with that philosophy;
3. assess in-service training needs to ensure competency-based service delivery;
4. use all resources available to strengthen a compatible team approach, restructuring roles, responsibilities, and relationships if necessary;

5. evaluate on an ongoing basis to ensure that the philosophy of treatment remains dynamic, reflects profesional and programmatic growth, and the accumulation of knowledge and experience.

FOR DISCUSSION: A PROPOSED STATEMENT OF THE RIGHTS OF YOUNG CHILDREN IN A MENTAL HEALTH CENTER

When receiving services from a mental health center, children have the following rights:

1. to be treated as unique persons, separate from other systems, capable of learning and growing;
2. to receive services from a *mental health* rather than a *mental illness* perspective;
3. to be assessed by specialists who understand the ways children develop and who can supervise the implementation of the *whole child* approach to mental health;
4. to be treated by people who can assess milieu impact and who can provide advocacy, support, and therapeutic intervention through other systems in which child clients function--family, school, medical and human/social services;
5. to receive guidance through methods and under circumstances appropriate to their age and compatible with a nurturing, accepting, responsible and nonviolent

code of behavior that reflects their strengths and positive expectations for growth, i.e., with systems and service providers modeling behaviors it is hoped child clients will learn.

These broad rights can be interpreted and implemented through the following corresponding considerations:

1.) Each child is an integral system of potential, regardless of the hopelessness or dysfunctional level of other systems in which he or she lives. Primary attention will be given to the needs of children as capable, growing beings with emphasis on acquisition of communication and coping skills. No child will be penalized or abandoned because of lack of commitment from family or others. Likewise, no child will be made the scapegoat for a dysfunctional family for the purposes of record keeping or to assuage resistive parents. Upon referral, children who have been identified as having problems will be given individual attention. It will not be assumed that family or group therapy--though that may be part of a collateral plan--will meet all of the needs of children. Where protection is an issue, where the possibility of child abuse/neglect exists, it is vital to children's safety and wellbeing that they have their own therapists, in addition to those whose focus is the family.

2.) Psychiatric and psychological diagnostic definitions and requirements make it an especially important challange to protect children from detrimental labeling. Diagnostic codes will reflect no, or the least

degree of, impairment unless assessed by a child psychiatrist or psychologist, or child specialist under their supervision, for the purposes of obtaining specialized services. Every precaution should be taken to ensure that developmental and age-expected behaviors do not get labeled as categories of mental illness. Further, if necessary, child development specialists will advocate for information systems that reflect the educational and consultative nature of many of their services to well adjusted, mentally healthy, developing people. When psychiatric and psychological referrals are made, therapy should be developmentally oriented for the purposes of facilitating growth and assessing progress.

3.) Categories of assessment will be defined by purpose and experience level of the evaluator. The following levels of service were proposed by a Maine task force defining comprehensive services to young children (STANDARDS FOR PREVENTIVE CHILD HEALTH CARE):

a. Screening: Informal observation of overall growth and development with concerns referred for assessment. Done by parents, students, paraprofessionals, volunteers, entry-level and non-specializing professionals.

b. Assessment/Comprehensive Developmental Assessment:Informal and formal observation and standardized testing of overall growth and development with referrals for further testing, as indicated . Done by child developmental specialists from health, mental health and education.

c. Diagnostic Evaluation: Formal observation and standardized testing for the purpose of diagnostic documentation. Done by child psychologists, psychiatrists, child development or other specialists with appropriate

training, experience, and clinical supervision.

d. Family Assessment: Observation of a family unit/system by a psychologist, psychiatrist or family specialist with appropriate training, experience and clinical supervision.

e. Home Assessment: Observation of a living environment by a psychologist, psychiatrist, family specialist, child development or other specialist with appropriate training, experience, and clinical supervision.

The term *assessment* should not be used loosely to refer to the introductory problem identification step in the intake process. Assessment implies an indepth examination by a specialist in the area(s) of the presenting problem(s).

The rights of children and their families will be protected by adherence to levels of service similar to those above. Likewise, credentialing standards of the various professions and disciplines will be maintained.

Regular and adequate supervision to child development workers will ensure attention to the whole child by providing feedback, support, information and resources. Supervision by a child development team coordinator will be characterized by a developmental approach to individual professional growth and skill acquisition. It will be the role of the team coordinator to evaluate and facilitate team process and program development, complemented by reciprocal support and the assumption of individual responsibility on the part of each member.

Standardized treatment based on theoretical stance more than knowledge of each child's individual case will be avoided and will

distinguish the team as a child development team. This will protect the child development workers as well as the children.

Administrative and clinical supervision must mesh. It must be compatible, at the least. The child development team should be supervised programmatically by a child development specialist with access to consulting relationships in other disciplines.

It is the responsibility of the child development specialist to interpret the developmental approach to mental health as necessary within the agency, to consumers, to cooperating agencies, and to the community , as required by job description.

4.) When the family, school, or other system has been identified as having a causal relationship to a child's problem(s), the child will be provided with collateral consultative and therapeutic support in the form of advocacy and follow-through. Such plans will be determined at team intake, case and peer review, by case managers, and in consultation with supervisors.

5.) Methods through which the above conditions will be implemented will be defined by the team after the treatment philosophy has been written, and in accordance with agency quality assurrance standards. Once determined, methods will be translated into direct policy and procedures that will be reflected in the ways children receive treatment at the mental health center. Following are examples of basic service delivery considerations based on the rights and special characteristics of young children. Although they may seem obvious, use of

this list as an evaluative checklist will show lack of adherence in many agencies.

a. Appointment and access times will not conflict with nap or mealtimes.

b. Young children will not be expected to wait for long periods of time.

c. A therapeutic waiting area will be provided with age appropriate furnishings and supervison, especially when space is shared with adolescent and adult clients.

d. Children will not be discussed within their hearing or that of others, unless they are part of a session and included as participants--spoken to, not about.

e. Children will not be treated as if misbehaving in circumstances requiring behavior beyond their developmental capabilities, such as impatience and acting out during long adult sessions or at other times and in other circumstances inappropriate to young children.

f. Children will not have their space or person violated by adults who pursue, hold, tickle, etc., against their will (e.g. by insensitive, inexperienced or untrained staff), especially contraindicated in cases of physical or sexual abuse in which case misuse of adult power is always a contributing factor.

g. Acting out children will be helped with gentle but firm restraint from hurting themselves or others.

h. Children will be taught alternatives and choices about behavior, preferably through modeling and multi-media parent education.

i. Centers which provide services to young children will evaluate the environment to assure that it is nonthreatening, provides privacy, and that what happens there conveys the message that children are respected, valued, and encouraged (never ridiculed, discounted, or treated in a patronizing way).

j. Child development workers will advocate for record keeping systems which recognize the importance of collecting drawings, stories, and other samples of children's expressions, even if such material doesn't fit the standard information management systems designed for case records of adult treatment.

k. Children will be assigned therapists, workers, helpers, who are most appropriate by training and experience rather than by degree or third party reimbursability.

SUMMARY

These kinds of general standards have direct impact on program implementation and should be interpreted from the point of view of young children coming to a mental health center. Guidelines for making and managing spaces for young children are available through the National Association for the Education of Young Children.

Although the ultimate responsibility for addressing the foregoing concerns rests with supervisors and program managers, each service provider and staff person owns the responsibility for his or her professional behavior as well as responsibility toward team accountability and quality assurrance standards. The child development specialist will constantly be alert to the nature of the experience for child clients coming

to a mental health center and work toward conditions which model the highest in adult-child interaction, including especially, positive expectations built on individual strengths and potential. Toward that end, this paper is intended as a tool to provoke discussion, problem solving, and progress on behalf of young children.

Termination

I cleaned out y/our files today, Joey,
what we've called "Our Plans".
That is, I threw away
"nonessential record content"
according to clinical policies,
(as if your drawings , stories, and thoughts
from our time together are nonessential).
There were several files.
After all, it's been three years, little boy,
too frightened to be afraid,
too angry to be mad, too sad to cry,
too vulnerable to be close.
I've done what's expected--
filled a trash can with you:
your pain, progress, struggles, successes.
So there's a nice thin file
with the Information System stuff,
the Chronological Summary of Activity, etc.,
that mostly documents and little that describes,

although I have insisted that my report
on what I have learned about you be left,
even if it has to be clipped at the top
instead of the sides,
and even if it is thicker
because it contains more of you.
THE TRANSITION. ENDINGS AND BEGINNINGS time.
And you and I must find a way to let each other know
that the feelings don't get discarded as
"nonessential case material",
and how to say goodbye,
and how to celebrate that now (you wrote on your list)
you can: "1. be angry
2. be sad
3. be afraid
4. be happy
5. be skared
6. writet cursive."

Patricia Smith Ranzoni

BIBLIOGRAPHY

Dixon, G. Child Development in the Family Health Care Center. Young Children, Journal of the National Association for the Education of Young Children, March 1980, p. 49-56.

Mohite, P. Role of a Child Development Worker in a Clinical setup with Special Reference to Child Guidance Clinic. Child Psychiatry Quarterly v. 12 #1 January-March 1979, p. 7-12.

Publications List, National Association for the Education of Young Children, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009.

Ranzoni, P. Come Search With Me! A Challenge to Child Development Specialists-Counselors on the Importance of Research. Manuscript submitted for publication, 1983.

Ranzoni, P. Roles and Responsibilities of the Child Development Specialist as Related to Child Abuse/Neglect. Unpublished paper, 1983.

Ranzoni, P. Sexual Abuse of Children: A Training Model for Child Development Specialists/Workers ERIC Clearinghouse on Elementary and Early Childhood Education, Document #PS014499, 1984.

Ranzoni, P. The Child Development Specialist as Counselor, Unpublished paper. 1983.

Ranzoni, P. The Child Development Specialist in Search of a Professional Identity, Unpublished manuscript. 1983.

Ranzoni, P. The Psychiatrist and Child Development Specialist: A Team Approach to Child Abuse in Maine. POCA PRESS, Journal of the

Psychiatric Outpatient Centers of the Americas. November 1984, p. 8-14.

S.C.A.N. Manual (Suspected Child Abuse/Neglect), Eastern Maine Medical Center, Bangor, Maine, 04401.

Schmitt, M. (Ed.) The Child Protection Team Handbook, A Multi-Disciplinary Approach to Managing Child Abuse/Neglect Department of Pediatrics, University of Colorado Medical Center, Denver, Colorado. Garland STPM Press: New York, (Chapter 11, The Developmental Specialist's Evaluation of the Child) 1978, p. 135-148.

Sheldon, C. and Morgan, C. The Child Development Specialist: A Prevention Program The Personnel and Guidance Journal April, 1984, p. 470-474.

Sgrois, S. Handbook of Clinical Intervention in Child Sexual Abuse Lexington Books: Lexington, Massachusetts, 1982.

STANDARDS FOR PREVENTIVE CHILD HEALTH CARE Early, Periodic, Screening, Diagnosis and Treatment Program, State of Maine Department of Human Services, Augusta, Maine 04330, 1982.

The Role of the Mental Health Professional in the Prevention and Treatment of Child Abuse/Neglect D.H.E.W. publication # (OHDS) 79-30194. 1979.

© 1986 Patricia Smith Ranzoni. All Rights Reserved